

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 11. STATE BOARD OF DENTAL EXAMINERS

Editor's Note: The following Notice of Proposed Rulemaking was exempt from Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 742.)

[R14-30]

PREAMBLE

- 1. Article, Part or Section Affected (as applicable)**

R4-11-402	Amend
R4-11-403	New Section
R4-11-404	New Section
R4-11-405	Amend
R4-11-406	Amend
- 2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. §§ 32-1207(A)(1) and (12), 32-1207(B)(3), and 32-1207(E) and (F)

Implementing statute: A.R.S. §§ 32-1213(B)(4), (C), and (D), 32-1236(C), (F), and (G), 32-1262(D), 32-1287(C) and (F), 32-1297.04, 32-1297.06, and 32-1299.23
- 3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Rulemaking Docket Opening: 20 A.A.R. 460, February 21, 2014
- 4. The agency's contact person who can answer questions about the rulemaking:**

Name:	Elaine Hugunin, Executive Director
Address:	State Board of Dental Examiners 4205 N. 7th Ave., Suite 300 Phoenix, AZ 85013
Telephone:	(602) 242-1492
Fax:	(602) 242-1445
E-mail:	elaine.hugunin@azdentalboard.us
Website:	www.azdentalboard.us
- 5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

House Bill 2744 enacted August 2, 2012 amended A.R.S. § 41-1008 to require an agency to establish or increase a fee within rules.

Per Statute, the Board is required to establish the license and renewal fee for Dentists, Dental Consultants, Dental Hygienists and Denturists at least every three years in a public meeting. To be able to collect the fee, the Board needs to establish the fees in rule. The license fees will be placed in New Section R4-11-403 License and Renewal Fees.

Other fees which need to be established in rule are:

A Business Entity Late fee - statutory authority A.R.S. § 32-1213(D),

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Mobile Dental Facility and Portable Dental Unit:

Permit/registration Fee statutory authority A.R.S. § 32-1299.23(A),
Late fee statutory authority A.R.S. § 32-1299.23(A), and

Address/Contact Penalty statutory authority A.R.S. § 32-1299.23(B) will be placed in New Section R4-11-404 Mobile Dental Facility and Portable Dental Unit Fees.

The language in R4-11-402(B) is being deleted, because there is no valid reason for having a civil penalty fee in rule. The Board imposes civil penalties by Board order not by rule. This subsection of rule has never been used, and the agency staff cannot find a reason or need for the language.

The rule will include format, style, and grammar necessary to comply with the current rules of the Secretary of State and the Governor's Regulatory Review Council. The Board believes that approval of these rules will benefit the public health and safety by clearly establishing the fees collected by the Board.

- 6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The agency did not review or rely on any study relevant to the rule.

- 7. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

- 8. The preliminary summary of the economic, small business, and consumer impact:**

The proposed rules will impact the Board, licensees, business entities, mobile dental facilities, portable dental units, and the public. The amended rule's impact on the Board will be the usual rulemaking-related costs, which are minimal.

The Board estimates the amended rules will have minimal economic impact on licensees, business entities, mobile dental facilities, portable dental units. A.R.S. § 32-1299.23 requires the Board to issue a permit to an individual or entity to operate at mobile dental facility or portable dental unit. The statutes requires the Board to establish a fee for the permit in rule. The Board established the annual fee of \$50 for each permit. The Board estimates there will be 21 mobile dental facilities or mobile dental units the first year. The cost to each individual or entity will be \$50 per year. The cost to the individual or entity is minimal.

A.R.S. § 32-1299.23 requires the Board to establish and impose a late fee on a permit holder whose permit expires and a penalty fee on a permit holder who fails to notify the Board of changes to address or contact persons within 10 days. The Board estimates the number of late fee or penalty fee violations could be from zero to 10 percent of the number of permits issued. The cost to individual permit holders would be \$50 for late fee and \$50 for penalty fee, which is minimal.

A.R.S. § 32-1213 requires the Board to establish and impose a late fee on a business entity whose registration expires. The Board estimates the number of late fee violations could be from zero to 10 percent of the number of registrations issued. The cost to individual registrants would be \$100, which is minimal.

The amended rules have no economic impact on the public.

The Board, licensees, licensees, business entities, mobile dental facilities, portable dental units, and the public benefit from rules that are clear, concise, and understandable. The rules' benefit the public health and safety by clearly establishing the fees collected by the Board.

- 9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:**

Name: Elaine Hugunin, Executive Director
Address: State Board of Dental Examiners
4205 N. 7th Ave., Suite 300
Phoenix, AZ 85013
Telephone: (602) 242-1492
Fax: (602) 242-1445
E-mail: elaine.hugunin@azdentalboard.us
Website: www.azdentalboard.us

- 10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is**

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scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Comments may be written or presented orally. Written comments must be received by 5:00 p.m., Monday, April 21, 2014. An oral proceeding is scheduled for:

Date: April 21, 2014
Time: 10:00 a.m.
Location: 4205 N. 7th Ave., Suite 300
Phoenix, AZ 85013

A person may request information about the oral proceeding by contacting the person listed above.

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

Not applicable

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rules do not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

No

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 11. STATE BOARD OF DENTAL EXAMINERS

ARTICLE 4. FEES

Section

R4-11-402. Business Entity Fees
R4-11-403. ~~Repealed~~ Dentist, Dental Hygienist and Denturist Triennial Renewal Fees and Prorated Initial License Fees
R4-11-404. ~~Repealed~~ Mobile Dental Facility and Portable Dental Unit Fees
R4-11-405. Other Fees
R4-11-406. ~~Fees for Anesthesia and Sedation Permits~~ Permit Fees

ARTICLE 4. FEES

R4-11-402. Business Entity Fees

- A. Under A.R.S. § 32-1213(B)(3), the fee for a Business Entity registration is: \$100.00 per year, per location.
B. The civil penalty fee for failure to notify the Board of a change in either business entity name, address, telephone number, location of any office, or licensee responsible for dental services within 30 days after the change is \$50. The civil penalty fee increases to \$100 if a business entity fails to notify the Board of the change within 60 days. Business Entity registration renewal late fee: \$100.00.

R4-11-403. ~~Repealed~~ Dentist, Dental Hygienist and Denturist Triennial Renewal Fees and Prorated Initial License Fees

- A. Dentist triennial renewal fee: \$600.00.
B. Dentist prorated initial license fee: \$110.00.
C. Dental hygienist triennial renewal fee: \$300.00.
D. Dental hygienist prorated initial license fee: \$55.00.
E. Denturist triennial renewal fee: \$275.00.
F. Denturist prorated initial license fee: \$46.00.

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R4-11-404. ~~Repeated~~ Mobile Dental Facility and Portable Dental Unit Fees

- A.** Mobile dental facility annual fee is \$50.00.
- B.** Mobile dental facility late fee: \$50.00.
- C.** Portable dental unit annual fee is \$50.00.
- D.** Portable dental unit late fee: \$50.00.
- E.** Mobile dental facility failed notification penalty fee: \$50.00.
- F.** Portable dental unit failed notification penalty fee: \$50.00.

R4-11-405. Other Fees

- A.** Duplicate license: \$25.00.
- B.** Duplicate certificate: \$25.00.
- C.** License verification:
 - 1. For licensee: \$25.00.
 - 2. For non-licensee: \$5.00.
- D.** Copy of ~~tape~~ audio recording: \$10.00.
- E.** Photocopies (per page): \$0.25.
- F.** Mailing lists:
 - 1. Dentists:
 - a. In-state - paper or labels: \$150.00.
 - b. All licensees - paper or labels: \$175.00.
 - c. ~~Computer disk~~ Digital format: \$100.00
 - 2. Dental hygienists:
 - a. In-state - paper or labels: \$150.00.
 - b. All licensees - paper or labels: \$175.00.
 - c. ~~Computer disk~~ Digital format: \$100.00.
 - 3. Denturists: All certificate holders - paper, ~~or~~ labels, or digital format: \$5.00.
- G.** Board meeting agendas and minutes (mailed directly to consumer):
 - 1. Agendas and minutes (annual fee): \$75.00.
 - 2. Agendas only (annual fee): \$25.00.
 - 3. Minutes only (annual fee): \$50.00.
- H.** Denturist jurisprudence examination fee: \$250.00.

R4-11-406. Fees for Anesthesia and Sedation Permits Fees

- A.** ~~Under A.R.S. § 32-1207(D), the fee for a Permit fees:~~
 - 1. Section 1301 permit to administer general anesthesia and semi-conscious sedation or a fee: \$300.00.
 - 2. Section 1302 ~~or~~ permit fee: \$300.00.
 - 3. Section 1303 permit to administer conscious or oral conscious sedation fee: \$300.00.
 - 4. Section 1304 permit fee: is \$300.00 per location.
- B.** Upon successful completion of the initial onsite evaluation and upon receipt of the required permit fee, the Board shall issue a separate Section 1301, 1302, ~~or~~ 1303, or 1304 permit to a dentist for each location requested by the dentist. A permit expires on December 31 of every ~~third~~ fifth year.
- C.** ~~The renewal fee for each Permit renewal fees:~~
 - 1. Section 1301 permit renewal fee: \$300.00.-
 - 2. Section 1302, ~~or~~ permit renewal fee: \$300.00.
 - 3. Section 1303 permit is renewal fee: \$300.00 per location.
 - 4. Section 1304 permit renewal fee: \$300.00.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 742.) The Governor's Office authorized the notice to proceed through the rulemaking process on August 14, 2014.

[R14-39]

PREAMBLE

- 1. Article, Part, or Section Affected (as applicable)**

R9-22-202	Amend
R9-22-205	Amend
R9-22-209	Amend
R9-22-210	Amend
R9-22-213	Amend
R9-22-215	Amend
- 2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 36-2903.01(E)
Implementing statute: A.R.S. § 36-2907
- 3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Rulemaking Docket Opening: 20 A.A.R. 729, March 21, 2014 (*in this issue*)
- 4. The agency's contact person who can answer questions about the rulemaking:**

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov
- 5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Administration must conduct a rule-making to implement the elements of Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010), that relate to changes to covered services regarding well exams, and other cost-effective services. In addition to "clean up" of rules related to scope of services, such as updating cross-references and non-substantive changes to improve clarity. The provisions are necessary to comply with federal or state requirements.
- 6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

A study was not used or relevant to this rulemaking.
- 7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

This rulemaking does not diminish a previous grant of authority to any political subdivisions of the state.

Notices of Proposed Rulemaking

8. The preliminary summary of the economic, small business, and consumer impact:

This rulemaking is estimated to have a minimal economic impact on the implementing agencies and taxpayer of approximately \$850,000 over a one year time-frame, this assumes a 5% increase is experienced under the physical therapy clarification.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Website: www.azahcccs.gov

10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of March 10, 2014. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., April 28, 2014.

Date: April 28, 2014
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: April 28, 2014
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
1010 N. Finance Center Dr, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: April 28, 2014
Time: 2:00 p.m.
Location: 2717 N. 4th St. STE 130
Flagstaff, AZ 86004
Nature: Public Hearing

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

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c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION**

ARTICLE 2. SCOPE OF SERVICES

Section

- R9-22-202. General Requirements
- R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services
- R9-22-209. Pharmaceutical Services
- R9-22-210. Emergency Medical Services for Non-FES Members
- R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
- R9-22-215. Other Medical Professional Services

ARTICLE 2. SCOPE OF SERVICES

R9-22-202. General Requirements

- A.** For the purposes of this Article, the following definitions apply:
 - 1. "Authorization" means written, verbal, or electronic authorization by:
 - a. The Administration for services rendered to a fee-for-service member, or
 - b. The contractor for services rendered to a prepaid capitated member.
 - 2. Use of the phrase "attending physician" applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
 - 1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
 - 2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
 - 3. The Administration or a contractor may waive the covered services referral requirements of this Article.
 - 4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
 - 5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
 - 6. A member may receive behavioral health services as specified in Articles 2 and 12.
 - 7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
 - 8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
 - 9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously, and
 - c. Personal care items except as specified under R9-22-212.
 - 10. Medical or behavioral health services are not covered services if provided to:
 - a. An inmate of a public institution;
 - b. A person who is in residence at an institution for the treatment of tuberculosis; or
 - c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.
- C.** The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

- E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F. A service is not a covered service if provided outside the GSA unless one of the following applies:
 - 1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 - 2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
 - 3. The contractor authorizes placement in a nursing facility located out of the GSA; or
 - 4. Services are provided during prior period coverage or during the prior quarter coverage.
- G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J. The restrictions, limitations, and exclusions in this Article do not apply to the following:
 - ~~1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and~~
 - 2. A contractor electing to provide noncovered services.
 - a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 - b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
- K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
 - 1. R9-22-205(A)(8),
 - 2. R9-22-205(B)(4)(f),
 - 3. R9-22-206,
 - 4. R9-22-207,
 - 5. R9-22-212(C),
 - 6. R9-22-212(D),
 - 7. R9-22-212(E)(8),
 - 8. R9-22-215(C)(2), and
 - 9. R9-22-215(C)(5).

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

- A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
 - 1. Periodic health examination and assessment;
 - 2. Evaluation and diagnostic workup;
 - 3. Medically necessary treatment;
 - 4. Prescriptions for medication and medically necessary supplies and equipment;
 - 5. Referral to a specialist or other health care professional if medically necessary;
 - 6. Patient education;
 - 7. Home visits if medically necessary; and
 - 8. Except as provided in subsection (B), preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.
- B. The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
 - 1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
 - 2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the

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following:

- a. Qualification for insurance,
 - b. Pre-employment physical evaluation,
 - c. Qualification for sports or physical exercise activities,
 - d. Pilot's examination for the Federal Aviation Administration,
 - e. Disability certification to establish any kind of periodic payments,
 - f. Evaluation to establish third-party liabilities, or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
 4. The following services are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - b. Pregnancy termination counseling services;
 - c. Pregnancy terminations, unless required by state or federal law.
 - d. Services or items furnished solely for cosmetic purposes;
 - e. Hysterectomies unless determined medically necessary; and
 - f. ~~Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.~~

R9-22-209. Pharmaceutical Services

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
 1. Available during customary business hours, and
 2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:
 1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- D. The following limitations apply to pharmaceutical services:
 1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 2. ~~A new prescription or refill in excess of 100-unit doses a 30 day supply is not covered unless specified in subsection (D)(3).~~
A new prescription or refill in excess of a 30-day supply is not covered unless specified in subsection (D)(3).
 3. ~~A prescription or refill in excess of a 30-day supply is covered if:~~
 - a. ~~The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.~~
 - b. ~~a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 a 90 day supply or 100-unit doses, whichever is greater.~~
 - c. ~~The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
 - d. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
 4. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

R9-22-210. Emergency Medical Services for Non-FES Members

- A. General provisions.
 1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
 2. Definitions.
 - a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS, ~~or Children's Rehabilitative Services.~~
 - b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
 3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if

- eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
 - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
 - b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
 5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
 - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
 - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
 - c. Deny or limit payment because the provider does not have a subcontract.
 6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; and
 - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.**
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
 2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
 3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
 4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.
- C. Post-stabilization services for non-FES members enrolled with a contractor.**
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
 2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
 3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
 4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The contractor does not respond to a request for prior authorization within one hour;
 - b. The contractor authorized to give the prior authorization cannot be contacted; or
 - c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
 - ii. A contractor physician assumes responsibility for the member's care through transfer,
 - iii. The contractor's representative and the treating physician reach agreement concerning the member's care,or
 - iv. The member is discharged.
 5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.
- D. Additional requirements for FFS members.**
1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.

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2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

A. The following E.P.S.D.T. services are covered for a member less than 21 years of age:

1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses; ~~and~~
 - c. Prescriptive lenses; and
 - d. Frames.
3. Hearing services including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment; and
 - c. Hearing aids;
4. Dental services including:
 - a. Emergency dental services as specified in R9-22-207;
 - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
 - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. ~~Medically necessary.~~ Nutritional ~~nutritional~~ assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services as follows:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
 - c. Hospice services do not include:
 - i. ~~Medical services provided that are not related to the terminal illness; or~~
 - ii. ~~Home-delivered meals; and~~
 - d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS;
9. Incontinence briefs as specified under R9-22-212; and
10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

B. Providers of E.P.S.D.T. services shall meet the following standards:

1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
4. Refer a member as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

D. A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

R9-22-215. Other Medical Professional Services

A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:

1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:

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- a. Medications,
 - b. Supplies,
 - c. Devices, and
 - d. Surgical procedures;
3. Family planning services are limited to:
- a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
12. ~~Inpatient chemotherapy~~ Chemotherapy; ~~and~~
13. ~~Outpatient chemotherapy.~~
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
 2. Dialysis shunt placement;
 3. Arteriovenous graft placement for dialysis;
 4. Angioplasties or thrombectomies of dialysis shunts;
 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
 6. Eye surgery for the treatment of diabetic retinopathy;
 7. Eye surgery for the treatment of glaucoma;
 8. Eye surgery for the treatment of macular degeneration;
 9. Home health visits following an acute hospitalization (limited up to five visits);
 10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
 11. Physical therapy subject to the limitation in subsection (C);
 12. Facility services related to wound debridement,
 13. Apnea management and training for premature babies up to the age of 1; and
 14. Other services identified by the Administration through the Provider Participation Agreement.
- C.** The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
 2. ~~Physical therapy provided only as a maintenance regimen;~~
 3. ~~Abortion counseling;~~
 4. ~~Services or items furnished solely for cosmetic purposes;~~
 5. ~~Services provided by a podiatrist; or~~
 6. ~~More than 15 outpatient physical therapy visits per benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.~~
 5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
 6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.